Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Lithium Therapy in the Elderly

TO THE EDITOR: This is in response to the article "Lithium Treatment for Psychiatric Disorders" (West J Med 128:488-498, June 1978). The authors state that lithium is a safe drug for the elderly. Although they correctly state that the dose should be reduced, they fail to elaborate on this point.

Although lithium appears to be as effective in the control of manic states in the elderly as it is in younger patients with cyclic mood disorders, clinical experience in the elderly has shown that severe reactions to the drug could develop quite rapidly, sometimes as early as 15 minutes after an initial dose. All of the usual toxic side effects of lithium are seen in the elderly, as well as in the young. However, particular attention has been focused on the frequent appearance of an acute brain syndrome (associated with neuromuscular irritability and impaired consciousness) as a predominant sign of lithium toxicity.[1] Crews and co-workers[2] suggested that lithium toxicity may be expressed as an aggravation of a tardive dyskinesia already present to a minimal degree, while others suggest that lithium might improve this syndrome.[3] Friedman[4] states that elderly patients are more susceptible to the cognitive effects of lithium, although no one knows the natural history of manic depressive illness, with or without therapy. Others have also commented that patients will complain of subtle memory loss while taking lithium, and report a return to normal memory after discontinuing the drug.

In order to avoid such problems, a dose titration has been devised and used over the years. There seems to be agreement that dosage of lithium should be initiated at well under 900 mg per day.[5,6] The need for lower daily doses to achieve adequate blood levels relates to the longer half-life of lithium in the elderly. The half-life in the aged is twice that of younger patients, and because lithium is primarily excreted in the urine, the prolonged half-life is related to renal aging. It seems that serious side effects in the elderly occur on lower doses and at lower blood levels, but that there are no reports of serious side effects when lithium dosage is under 900 mg daily or when serum levels are under 1.0 mEq per liter. This lack of toxicity is consistent with initiating treatment at doses well under 900 mg per day, while at the same time maintaining a therapeutic response.

So in summary it can be said that lithium has been found to be quite effective in treating cyclic mood disorders in the elderly, and if the practitioner is aware of the problems of lithium use in the elderly, toxic side effects can be avoided.

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Lithium Treatment—A Correction

TO THE EDITOR: In the article on lithium therapy in the June issue (Maletzky BM, Shore JH: Lithium treatment for psychiatric disorders. West J Med 128:488-498, June 1978) there appears to be a serious error in Table 2 on page 494 concerning guidelines for the use of lithium in women of childbearing potential or who are pregnant.

The general theoretical consideration is that lithium is in equilibrium across the placental membrane and the amount of lithium in the

serum of the mother is equivalent to that amount of lithium to which the fetus is exposed.

Under F2 in this table, there is the following statement: "Use three times daily dose, or if available, sustained-release tablets. Avoid large single or double daily doses."

Using three times the daily dose could be severely toxic to the mother and fetus and could result in serious complications and even death.

In an attempt to avoid large single or double daily doses one would not use three times the daily dose. Instead, the usual procedure if lithium must be used during pregnancy is to divide the usual daily dose into more frequent administration of the lithium thereby avoiding more concentrated pulses of lithium that might adversely affect the fetus. *Do not use three times the daily dose* as this could be severely toxic to the mother and the fetus. Instead, use the lowest effective dose and divide the dosage into more frequent administrations.

A list of other articles published on this subject appears below.

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The Authors Reply

TO THE EDITOR: We thank Dr. Goldfield for his correction. In proofing the typescript of our article we missed this error. F2 in Table 2 should read "Use in divided doses, preferably three times a day, or, if available, sustained-release tablets. Avoid large single or double daily doses."

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BARRY M. MALETZKY, MD
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Hysteria by Any Other Name

TO THE EDITOR: On page 482 of the June issue there appeared an article by Dr. James R. Morrison entitled "Management of Briquet Syndrome (Hysteria)."

I have one objection: hysteria is not a syndrome but a well-known clinical entity. To attach the name Briquet to it because Briquet published a book on hysteria in 1859 is not justified. Moses Maimonides (1135 to 1204) described conversion hysteria as occurring long before the birth of Christ.

JULIUS BAUER, MD
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The Author Replies

TO THE EDITOR: Conversion hysteria is certainly an ancient affliction, but so is "hysteria" an ancient term—so old that it has been applied to a number of conditions. That is the point of the new term: to distinguish the collection of symptoms we now call Briquet syndrome from other, less well-defined usages.

Careful definition of this condition makes possible effective management. That was a major point of my article. Thank you for enabling me to make it again.

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